



RESTRAINT ALTERNATIVES



The following information suggests ideas for reducing physical restraint use. Carefully monitored use of the alternatives with frequent reassessment is suggested.

Restraint = Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that he or she cannot remove easily or that restricts freedom of movement or normal access to one's body.

General Principles	<ul style="list-style-type: none"> • Play to the resident's strengths. • Apply the five Magic Tools (knowing what the resident likes to See, Smell, Touch, Taste, Hear). • Be calm and self-assured. • Use pets, children, and volunteers. • Provide distractions based upon a resident's work/career. 	<ul style="list-style-type: none"> • Provide for a sense of security. • Know the resident's agenda. • Encourage independence. • Involve the family—give them a task. • Offer choices.
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Behavior/Medical Condition	Therapeutic Intervention	Environment & Equipment Intervention
Sliding or Leaning Out of Chair or Bed	<ul style="list-style-type: none"> • Evaluate medications that may produce lethargy or sluggishness. • Increased visual monitoring. • Evaluate physical needs such as toileting, comfort, pain. • Evaluate pain level. • Evaluate sleep pattern. • Place resident in bed when fatigued. • Evaluate for a Restorative Program. • PT/OT referral for screening. • Place the resident at the nurses station when not in activities, etc. • Periodic exercise program throughout the day. • Wheelchair/Chair pushups. • Activities to assess. • Frequently encourage repositioning. 	<ul style="list-style-type: none"> • Assistive devices (wedge cushion, half-lap tray, solid seat for wheelchair, side or trunk bolsters,ommel cushion, dycem, etc.). • Appropriate size chair & proper fit. • Alternative seating such as Adirondack chair, high back chair. • Bean bag chair, reclining wheelchair, nonwheeled chairs, wing-back chair. • Call bell in reach. • Over-bed table for providing diversional activities. • Water pitcher in reach. • Chair/bed alarm(s). • Mat on the floor.
Unsafe Mobility Unsteady Gait	<ul style="list-style-type: none"> • Evaluate medications that may produce gait disturbances. • Evaluate for orthostatic hypertension and change positions slowly. 	<ul style="list-style-type: none"> • Evaluate for proper fitting and appropriate condition of footwear. • Non-skid socks. • Evaluate ambulation devices for good working

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	<ul style="list-style-type: none"> • Evaluate visual system and proper correction of eye glasses. • Evaluate vestibular system, making sure ears are clear and balance system is intact. • Re-evaluate physical needs such as toileting program, comfort, and pain. • Exercise pedals while sitting. • Generalized activity programs. • Ambulation and/or exercise programs. • Group ambulation and/or accompanied walks in or out of doors. • 1:1 visitations. • Frequently encourage repositioning. • Identify customary routines (late sleepers and early risers) and allow for preferences. • Evaluate for a restorative program. • PT/OT referral for screening. 	<p>condition.</p> <ul style="list-style-type: none"> • Adequate lighting, especially at night. • Remove wheeled furniture used for support. • Bed lowered so resident can touch toes to the floor. • Place glasses on every day to enhance visual acuity. • Call bell in reach at all times. • Evaluate need for bedside commode at night. • Avoid use of throw rugs. • Floor alarm. • Motion detectors. • Bed &/or chair alarms. • Hip protectors. • Merry Walker—fade use as strength increases.
<p>Falling/Climbing Out of Bed</p>	<ul style="list-style-type: none"> • Evaluate for orthostatic hypotension and change positions slowly. • Re-evaluate physical needs such as toileting, comfort, pain, thirst, and timing of needs. • Provide h.s. snack. • 1:1 conversation. • Touch, if appropriate, while recognizing personal body space. • Anticipate customary schedules and accommodate personal preferences. • Evaluate balance for sub-clinical disturbances such as inner ear infections. • Validate feelings and mobilize the patient/resident. For instance “I want to get up.” — “You want to get up?” — then get the patient/resident up. • Evaluate hearing and vision. 	<ul style="list-style-type: none"> • Low bed. • Remove siderails. • Put mat on floor at bedside. • Bed or chair alarm. • Evaluate accessibility of call lights. • Nightlight. • Visual cues for staff on the patient’s/resident’s door to identify patients/residents at risk for falling. • Scoop mattress. • Evaluate physical environment for excessive furniture, cluttered hallways, rooms. • Visual cues to direct to toilet, use of gait devices, use of call bell. • Light, protective headgear. • Use a trapeze for bed mobility.



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	<ul style="list-style-type: none"> • Evaluate for appropriate shoes/foot apparel. • Evaluate for appropriate size and length of clothing. • Check blood sugar levels. • Evaluate sleep/wake patterns. • Evaluate for a Restorative Program. • PT/OT referral for screening. 	
<p>Verbally Abusive Physically Abusive</p>	<ul style="list-style-type: none"> • Begin with medical evaluation to rule out physical or medication problems. • Evaluate for acute medical conditions such as UTI, URI, ear infections, or other infections processes. • Evaluate for pain, comfort, and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges. • Attempt to identify triggering events or issues that stimulate the behavior. • Consider using behavior tracking form to assist in identification of triggers trending patterns. • Consult with family regarding past coping mechanisms that proved effective during times of increased stress levels. • Provide companionship. • Validate feelings, such as saying “You sound like you are angry.” • Redirect. • Active listening. Address potential issues identified. • Set limits. • Develop trust by assigning consistent caregivers whenever possible. • Avoid confrontation. Staff to decrease voice levels. • Approach in calm/quiet demeanor. • Provide rest periods. • Social Services referral. • Psychologist/Psychiatrist referral. 	<ul style="list-style-type: none"> • Relaxation techniques (tapes, videos, music, etc.). • Theme/Memory/Reminiscence boxes/books. • Magnification box to create awareness of the patient’s/resident’s voice level and provide feedback. • Lava lamp, soothe sounders, active mobile. • Tapes of family and/or familiar relatives or friends. • Move to a quiet area, possibly a more familiar area. Decrease external stimuli. • Fish tanks.



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	<ul style="list-style-type: none"> • Touch therapy and/or massage (hand or back). • Reduce external stimuli (overhead paging, TV, radio noise, etc.). • Evaluate staffing patterns/trends. • Evaluate sleep/wake patterns. • Maintain regular schedule. • Limit caffeine. • Punching bag. • Avoid sensory overload. 	
<p>Pacing/Wandering At Risk for Elopement</p>	<ul style="list-style-type: none"> • Find ways to meet resident's/patient's need to be needed, loved, AND busy while being sensitive to their personal space. • Diversional activities that correspond with past lifestyles/preferences. • Consider how medications, Dx, ADL schedule, weather, or other patients/residents affect or relate to wandering. • Evaluate need for a "Day Treatment Program" for targeted residents. • Theme/Memory/Reminiscence boxes. • Companionship. • Provide opportunities for exercise, particularly when waiting. • Pre-meal activities. • Singing, rhythmic movements, dancing, etc. • Identify customary routines and allow for preferences. • Photo collage or album of memorable events. • Structured high-energy activity and subsequent relaxation activities. • Alternate rest and activity periods. • Distraction/redirection. • Written/verbal reassurance about where he/she is 	<ul style="list-style-type: none"> • Remove objects that remind the patient/resident of going home (hats, coats, etc.). • Individualize the environment. Make it home. Provide familiar objects. • Large numerical clock at bedside to provide orientation to time of day as it relates to customary routines. • Safe courtyard. • Decrease noise level (especially overhead paging at h.s.). • Door guards, barrier stripes. • Warning bells above the doors to alert staff of attempted elopement. • Camouflaging of doors. • Visual cues to identify safe areas. • Cover door knobs. • Put mirror at exits. • "Stop" and "Go" signs. • Wanderguard system. Relaxation tapes. • Visual barriers, murals. • Wandering paths. • Room identifiers. • Rest areas in halls. • Floor patterns.



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	<p>and why.</p> <ul style="list-style-type: none"> • Alleviate fears. • Ask permission before you touch, hug, etc. • Assess/Evaluate if there is a pattern in the pacing or wandering. • Assess for patient’s/resident’s personal agenda and validate behaviors. • Ask family to record reassuring message on tape. • Evaluate for a Restorative Program. • Perform physical workup. 	

This material is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.

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